

CARDIOVASCULAR DISEASE IN SOUTH EAST ASIA

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Cardiovascular Disease is number one killer in the world, followed by communicable diseases, cancer treatment and others. About 30% of overall mortality is attributed to CAD.¹ WHO figures are very alarming. It is reported that 1 billion people are overweight including 18 million children of age <5 years. Moreover 60% of the world population is physically inactive. About 150 million people in the world are diabetic and these figures will double in 2025.² Statistics say that in spite of extensive anti tobacco campaigns all over the world, its consumption is still increasing. In developed countries, the burden of CVD among these populations is high and is expected to increase.

Presently the developing countries contribute a greater share to the absolute burden of CVD than the developed countries. It is projected that CVD mortality rates will rise in the developing countries over the next two to three decades due to an increase in life expectancy and lifestyle changes. Also shown that CVD has reached epidemic proportions in many developing countries. In South East Asia, mortality attributable to CVD is expected to rise by 103% in men and by 90% in women from 1985 to 2015.³

The WHO stated in 2002 that in many regions, some of the most formidable enemies of health are joining forces with the allies of poverty to impose a double burden of disease, disability and premature death in millions of people.⁴ This is what is happening in South Asia, which has one quarter of the global population, where about half the population lives below the poverty line and has limited access to health care. Coronary heart disease rates have been reported in several parts of the world to be unusually high in people originating from the Indian subcontinent.

Heart diseases are rising in Asians 5–10 years earlier than in other populations around the world. The mean age for first presentation of acute myocardial infarction in Indians is 53 years.⁵ More importantly, the disease is increasing in young Asians. Therefore, to stop the ruthless assault of CVD in developing countries, there is an urgent need to represent the disease in the health agenda of these countries. A cost-effective preventive strategy will be needed to focus on reducing risk factors both in the individual and in the population at large.

The MONICA (Multinational Monitoring of trends and determinants in Cardiovascular disease) Project was established in the early 1980s in many centers around the world to monitor trends in cardiovascular diseases, and to relate these to risk factor changes in the population over a ten year period. It was

set up to explain the diverse trends in cardiovascular disease mortality which were observed from the 1970s onwards. There were total of 32 MONICA Collaborating Centres in 21 countries. The total population monitored was ten million men and women between 25-64 years age group. The ten year data collection was completed in the late 1990s. The largest decrease in coronary-event rates in men occurred in two northern European populations in Finland, where rates had been very high and where an active health promotion campaign was carried out.⁶ Populations that experienced increase in coronary event rates were mainly eastern (central and eastern Europe and Asia). Those with little improvement in case-fatality were populations that historically belonged to the eastern block.

If lifestyle changes contribute to increase risk factors in these populations, the observed rise in CVD mortality will be larger than these estimates. So to address the issue of prevention of CAD related events, life style modification seems to be key factor. The risk factor modification subject needs to be taught and included in school and higher education levels. Media role should be elaborated more.

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